

Information Governance

White Building Littlemore Mental Health Centre Sandford Road Littlemore Oxford OX4 4XN

Tel: 0845 219 1269 Fax: 0845 219 1275 Web: www.oxfordhealth.nhs.uk

19 March 2018 Reference no. 17180361

Dear

Request for Information: Freedom of Information Act

Thank you for your emails of 19 February, making a request for information under the Freedom of Information Act. You requested the following information and the Trust is able to provide the information below in response:

Request:

• The number of patients who have absconded from units after being admitted for mental health care over the last five calendar years (2013,2014,2015,2016,2017)? Please break this down by year.

For the purpose of this I am defining absconding to mean when a patient leaves the ward, hospital or an escort without prior agreement or consent from the clinical team.

• The number of inpatients who committed suicide while under NHS trust care in the last five years (2013,2014,2015,2016,2017)? Please break this down by year and provide any additional information about their death (eg how it took place and whether any investigations were launched around duty of care as a result)

Please can you provide information for suspected suicide and suicide as decided by the coroner, broken down into either category.

• The number of inpatients who self-harmed while under NHS trust care over the last five years (2013,2014,2015,2016,2017)? Please break this down by year and, if possible, detail how many individual self-harm attempts there were per patient.

Response:

Q1. The data below includes detained patients who have absconded from inpatient wards, from unescorted leave, escorted leave and also failure to return from leave

Year	Number of detained patients who absconded
2013	127
2014	118
2015	118
2016	121
2017	128

Q2. We have included all confirmed and suspected suicides, including those which did not happen on the ward.

	Number of inpatient suicides	Coroner conclusion	Detail around circumstances of death	Investigation completed?
2013	1	Narrative	Patient went AWOL from the ward and went aboard, was arrested however unfortunately took own life in a foreign jail.	Yes a serious incident RCA Investigation was completed including an independent investigator.
2014	1	Narrative	The patient was receiving treatment in local acute hospital for physical health needs. fell from stairs whilst at the acute hospital and died.	Yes a serious incident RCA Investigation was completed jointly between our trust and the acute trust.
2015	0			
2016	3	2 x suicide, 1 x narrative	2 patients failed to return from community leave. For both the coroner concluded suicide. 1 patient died on one of the Trust's wards. Narrative verdict.	Yes a serious incident RCA Investigation was completed for all 3 deaths. For the death on the ward an independent investigation was commissioned by the trust.
2017	2	Awaiting inquest	1 patient seriously self-harmed on the ward and later died in hospital. Inquest still to be held. 1 patient seriously self-harmed whilst on community leave and later died in hospital. Inquest still to be held.	Yes a serious incident RCA Investigation was completed for both deaths. The investigations were carried out by an independent investigator commissioned by the trust.

Year	Number of in-patients who self-harmed	Number of incidents of self-harm	Percentage of self-harm incidents reported as No Injury / No Property Damage
2013	188	871	48.11%
2014	192	1032	56.20%
2015	164	1325	52.15%
2016	162	1201	57.04%
2017	198	1289	58.96%

If you are unhappy with the service you have received in relation to your request and wish to make a complaint or request a review of our decision, you should write to me and I will ensure the decision is reviewed. The Trust will consider undertaking a review if requested to do so within 40 working days of the date the response is received by the applicant, and will apply discretion if a longer period of time has passed.

Should you wish to make a complaint as a result of the outcome of such a review, you may apply directly to the Information Commissioner's Office (ICO) for a decision.

Generally, the ICO cannot make a decision unless you have exhausted the complaints procedure provided by the Trust for FoI Act matters.

The ICO can be contacted at:

The Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire SK9 5AF

Please contact me if there are any further queries.

Kind regards,

Yours sincerely,

Mark Underwood

Head of Information Governance